UNITED HEALTHCARE INSURANCE COMPANY

UNITED HEALTHCARE DENTAL PPO CERTIFICATE OF COVERAGE

FOR

City of Arlington Texas

DENTAL PLAN NUMBER: P3946

GROUP NUMBER: GA-702632

EFFECTIVE DATE: January 1, 2007

Offered and Underwritten by

UNITED HEALTHCARE INSURANCE COMPANY

UnitedHealthcare®
A UnitedHealth Group Company

UNITED HEALTHCARE INSURANCE COMPANY

DENTAL CERTIFICATE OF COVERAGE

This Certificate of Coverage ("Certificate") sets forth your rights and obligations as a Covered Person. It is important that you READ YOUR CERTIFICATE CAREFULLY and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Enrolling Group.

United HealthCare Insurance Company ("Company") agrees with the Enrolling Group to provide Coverage for Dental Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Enrolling Group's application and payment of the required Policy Charges. The Enrolling Group's application is made a part of the Policy.

The Company shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. The Company shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan.

The Policy shall take effect on the date specified and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of the Policy as provided. All Coverage under the Policy shall begin at 12:01 a.m. and end at 12:00 midnight at the Enrolling Group's address.

The Policy is delivered in and governed by the laws of the State of Texas.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

UNITED HEALTHCARE INSURANCE COMPANY

Allen J. Sorbo, President

CERTIFICATE

Introduction

You and any of your Enrolled Dependents, for whom the required Premiums have been paid, are eligible for Coverage under the Policy. The Policy is referred to in this Certificate as the "Policy" and is designated on the identification ("ID") card.

Coverage is subject to the terms, conditions, exclusions, and limitations of the Policy. As a Certificate, this document describes the provisions of Coverage under the Policy but does not constitute the Policy. You may examine the entire Policy at the office of the Enrolling Group during regular business hours.

For Dental Services rendered after the effective date of the Policy, this Certificate replaces and supersedes any Certificate, which may have been previously issued to you by the Company. Any subsequent Certificates issued to you by the Company will in turn supersede this Certificate.

How To Use This Certificate

This Certificate should be read and re-read in its entirety. Many of the provisions of this Certificate are interrelated; therefore, reading just one or two provisions may not give you an accurate impression of your Coverage.

Your Certificate may be modified by the attachment of Riders and/or Amendments. Please read the provision described in these documents to determine the way in which provisions in this Certificate may have been changed.

Many words used in this Certificate have special meanings. These words will appear capitalized and are defined for you in the Section entitled Definitions. By reviewing these definitions, you will have a clearer understanding of your Certificate.

From time to time, the Policy may be amended. When that happens, a new Certificate or Amendment pages for this Certificate will be sent to you. Your Certificate should be kept in a safe place for your future reference.

Contracted and Non-Contracted Benefits

This Certificate describes both benefit levels available under the Policy.

Contracted Benefits - These benefits apply when you choose to obtain Dental Services from a Contracting Provider. The Section entitled Procedures for Obtaining Benefits describes the procedures for obtaining Covered Dental Services as Contracted Benefits. Unless otherwise noted in the Schedule of Covered Dental Services, Contracted Benefits are subject to payment of an Annual Deductible and generally require you to pay less to the provider than Non-Contracted Benefits. Contracted Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Contracting Provider an amount for a Covered Dental Service in excess of the contracted fee.

Non-Contracted Benefits - These benefits apply when you decide to obtain Dental Services from Non-Contracting Providers. The Section entitled Procedures for Obtaining Benefits describes the procedures for obtaining Covered Dental Services as Non-Contracted Benefits. Unless otherwise noted in the Schedule of Covered Dental Services, Non-Contracted Benefits are subject to an Annual Deductible and generally require you to pay more than Contracted Benefits. In addition, when you obtain Covered Dental Services from Non-Contracting Providers, you must file a claim with the Company to be reimbursed for Eligible Expenses. For information on the Company's reimbursement policy guidelines used to determine Eligible Expenses, you should contact the Company at the telephone number on your ID card.

The information in the Section entitled Definitions through the Section entitled Continuation of Coverage applies to both levels of Coverage. The Sections entitled Procedures for Obtaining Benefits and the Section

entitled Covered Dental Services explain the procedures you must follow to obtain Coverage for Contracted Benefits and Non-Contracted Benefits respectively. The Covered Dental Services Section describes which Dental Services are Covered. Unless otherwise specified, the exclusions and limitations that appear in the Section entitled General Exclusions apply to both levels of benefits. The Schedule of Covered Dental Services describes what Copayments are required, if any, and to what extent any limitations apply.

Dental Services Covered Under the Policy

In order for Dental Services to be Covered as Contracted Benefits, you must obtain all Dental Services directly from or through a Contracting Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling the Company. If necessary, the Company can provide assistance in referring you to Contracting Providers. If you use a provider that is not a participating provider, you will be required to pay the bill for the services you received.

Only Necessary Dental Services are Covered under the Policy. The fact that a Dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is Covered under the Policy.

The Company reserves the right, in accordance with federal and state law, to interpret the benefits Covered under the Policy and the other terms, conditions, limitations and exclusions set out in the Policy and to make factual determinations related to the Policy and its benefits. The Company may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to the Policy.

No person or entity has any authority to make any oral changes or amendments to the Policy.

The Company may, in certain circumstances for purposes of overall cost savings or efficiency and in its sole discretion, provide Coverage for services, which would otherwise not be Covered. The fact that the Company does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

The Company may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, including claims processing and utilization management services. The identity of the service providers and the nature of the services provided may be changed from time to time in the Company's sole discretion and without prior notice to or approval by Covered Persons. You must cooperate with those persons or entities in the performance of their responsibilities.

Similarly, the Company may, from time to time, require additional information from you to verify your eligibility or your right to receive Coverage for services under the Policy. You are obligated to provide this information. Failure to provide required information could result in Coverage being delayed or denied.

Important Note About Services

The Company does not provide Dental Services or practice dentistry. Rather, the Company arranges for providers of Dental Services to participate in a Contract. Contracting Providers are independent practitioners and are not employees of the Company. The Company, therefore, makes payment to Contracting Providers through various types of contractual arrangements. These arrangements may include financial incentives to promote the delivery of dental care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to Necessary Dental Services.

The payment methods used to pay any specific Contracting Provider vary. The method may also change at the time providers renew their contracts with the Company. If you have questions about whether there are any financial incentives in your Contracting Provider's contract with the Company, please contact the Company at the telephone number on your ID card. The Company can advise you whether your

Contracting Provider is paid by any financial incentive, including those listed above; however, the specific terms, including rates of payment, are confidential and cannot be disclosed.

The Dentist-patient relationship is between you and your Dentist. This means that:

- You are responsible for choosing your own Dentist.
- You must decide if any dentist treating you is right for you. This includes Contracting Providers who you choose or providers to whom you have been referred.
- You must decide with your Dentist what care you should receive.
- Your Dentist is solely responsible for the quality of the care you receive.

The Company makes decisions about benefit plan Coverage. These decisions are administrative decisions and are for payment purposes only. The Company is not liable for any act or omission of a provider of Dental Services.

Identification ("ID") Card

You must show your ID card every time you request Dental Services. If you do not show your card, the providers have no way of knowing that you are Covered under a Policy issued by the Company and you may receive a bill for Contracted Benefits.

If you do not have your card at the time you are requesting Dental Services, you or the Provider should call 1-877-816-3596 to obtain eligibility verification. For dental offices with Internet access, the Provider can also access www.dbp.com. This website provides current information on eligibility.

Contact the Company

Throughout this Certificate you will find statements that encourage you to contact the Company for further information. Whenever you have a question or concern regarding Dental Services or any required procedure, please contact the Company at the telephone number stated on your ID card.

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SECTION 1 - DEFINITIONS

This Section defines the terms used throughout this Certificate and is not intended to describe Covered or uncovered services.

"Amendment" - any attached description of additional or alternative provisions to the Policy. Amendments are effective only when signed by the Company. Amendments are subject to all conditions, limitations and exclusions of the Policy except for those, which are specifically amended.

"Annual Deductible" - the amount a Covered Person must pay for Dental Services in a calendar year before the Company will begin paying for Contracted Benefits in that calendar year.

"Annual Maximum Benefit" - the maximum amount paid for Covered Dental Services during a calendar year for a Covered Person under the Policy or any Policy, issued by the Company to the Enrolling Group, that replaces the Policy. The Annual Maximum Benefit is stated in the Schedule of Covered Dental Services.

"Congenital Anomaly" - a physical developmental defect that is present at birth and identified within the first twelve months from birth.

"Contracting Provider" - a Dentist who is subject to a participation agreement in effect with the Company, directly or through another entity, to provide Dental Services to Covered Persons. The participation status of providers will change from time to time.

"Contracted Benefits" - benefits available for Covered Dental Services when provided by a Dentist who is a Contracting Provider.

"Copayment" - the charge, in addition to the Premium, which you are required to pay for certain Dental Services provided under the Policy. A Copayment may either be a defined dollar amount or a percentage of Eligible Expenses. You are responsible for the payment of any Copayment directly to the provider of the Dental Service at the time of service or when billed by the provider.

"Coverage" or **"Covered"** - the entitlement by a Covered Person to reimbursement for expenses incurred for Dental Services covered under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy. Dental Services must be provided: (1) when the Policy is in effect; and (2) prior to the date that any of the individual termination conditions as stated in the Section entitled Termination of Coverage occur; and (3) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

"Covered Person" - either the Subscriber or an Enrolled Dependent while Coverage of such person under the Policy is in effect. References to "you" and "your" throughout this Certificate are references to a Covered Person.

"Dental Service" or "Dental Procedures" - dental care or treatment provided by a Dentist to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.

"Dentist" - any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental services, perform dental surgery or administer anesthetics for dental surgery.

"Dependent" - (1) the Subscriber's spouse or (2) an unmarried child of the Subscriber or the Subscriber's spouse including a natural child, stepchild, a legally adopted child, a child placed for adoption, a child for whom the Subscriber is a party in suit seeking adoption, a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber’s spouse, and a grandchild of the Subscriber who, at the time of initial enrollment, is claimed as a dependent by the Subscriber for federal income tax purposes.

The term "Dependent" shall not include any unmarried dependent child 25 years of age or older, except as stated in the sub-section of the Termination of Coverage Section entitled "Extended Coverage for Handicapped Children".

The Subscriber agrees to reimburse the Company for any Dental Services provided to the child at a time when the child did not satisfy these conditions.

The term "Dependent" also includes a child for whom dental care coverage is required through a "Qualified Medical Child Support Order" or other court or administrative order. The Enrolling Group or the Court of Order is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

The term "Dependent" does not include anyone who is also enrolled as a Subscriber, nor can anyone be a "Dependent" of more than one Subscriber.

"Eligible Expenses" - Eligible Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

A. For Contracted Benefits, when Covered Dental Services are received from Contracted Providers, Eligible Expenses are the Company's contracted fee(s) for Covered Dental Services with that provider.

B. For Non-Contracted Benefits, when Covered Dental Services are received from Non-Contracting Providers, Eligible Expenses are the usual and customary fees as defined below.

In the event that a provider routinely waives Copayments and/or the Annual Deductible for Non-Network Benefits, Dental Services for which the Copayments and/or Annual Deductible are waived are not considered to be Eligible Expenses.

"Eligible Person" - (1) an employee of the Enrolling Group; or (2) other person who meets the eligibility requirements specified in both the application and the Policy.

"Emergency" - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

"Enrolled Dependent" - a Dependent who is properly enrolled for Coverage under the Policy.

"Enrolling Group" - the employer or other defined or otherwise legally constituted group to whom the Policy is issued.

"Experimental, Investigational or Unproven Services" - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

A. Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

B. Subject to review and approval by any institutional review board for the proposed use; or

C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

"Initial Eligibility Period" - the initial period of time, determined by the Company and the Enrolling Group, during which Eligible Persons may enroll themselves and Dependents under the Policy.

"Medicare" - Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

"Necessary" - dental care services and supplies which are determined by the Company to be appropriate, and

A. necessary to meet the basic dental needs of the Covered Person; and

B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and

C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and

D. consistent with the diagnosis of the condition; and

E. required for reasons other than the convenience of the Covered Person or his or her Dentist; and

F. demonstrated through prevailing peer-reviewed medical and/or dental literature to be either:

    1. safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or,

    2. safe with promising efficacy

        a. for treating a life threatening dental disease or condition,

        b. in a clinically controlled research setting; and

        c. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe a dental disease or conditions that are likely to cause death within one year of the date of the request for treatment.)

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Certificate. The definition of Necessary used in this Certificate relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

"Non-Contracted Benefits" - coverage available for Dental Services obtained from Non-Contracting Providers.

"Non-Contracting Provider" - a Dentist who is not subject to a participation agreement in effect with the Company, directly or through another entity, to provide Dental Services to Covered Persons. The participation status of providers will change from time to time.

"Open Enrollment Period" - after the Initial Eligibility Period, a period of time determined by the Company and the Enrolling Group, that is at least 31 days long, during which Eligible Persons may enroll themselves and Dependents under the Policy. The period will occur annually and will not be less than an entire calendar month beginning on the first day of the month and ending on the last day of the month. If the month is February, the period will end on March 2nd.

"Physician" - any provider of medical services whose services are Covered under the Policy and Doctor of Medicine, "M.D.," or Doctor of Osteopathy, "D.O.," who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

"Policy" - the group Policy, the application of the Enrolling Group, Amendments and Riders which constitute the agreement regarding the benefits, exclusions and other conditions between the Company and the Enrolling Group.

"Policy Charge" - the sum of the Premiums for all Subscribers and Enrolled Dependents Covered under the Policy.

"Premium" - the periodic fee required for each Subscriber and each Enrolled Dependent in accordance with the terms of the Policy.

"Procedure in Progress" - all treatment for Covered Services that results from a recommendation and an exam by a Dentist. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

"Rider" - any attached description of Dental Services Covered under the Policy. Dental Services provided by a Rider may be subject to payment of additional Premiums and additional Copayments. Riders are effective only when signed by the Company and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended.

"Subscriber" - an Eligible Person who is properly enrolled for Coverage under the Policy. The Subscriber is the person on whose behalf the Policy is issued to the Enrolling Group.

"Usual and Customary" - Usual and Customary fees are calculated by the Company based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services. In the event that a provider routinely waives Copayments and/or the Annual Deductible for benefits, Dental Services for which the Copayments and/or the Annual Deductible are waived are not considered to be usual and customary.

Usual and Customary fees are determined solely in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association);
- As reported by generally recognized professionals or publications;
- As utilized for Medicare;
- As determined by medical or dental staff and outside medical or dental consultants;
- Pursuant to other appropriate source or determination accepted by the Company.

SECTION 2 - ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Section 2.1 Enrollment. Eligible Persons may enroll themselves and their Dependents for Coverage under the Policy during the Initial Eligibility Period or during an Open Enrollment Period by submitting a form provided or approved by the Company. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for Coverage under the Policy.

If you enroll for Coverage under the Policy, you must remain enrolled for a period of 12 months. If you disenroll at the end of any 12 month period, you must wait 12 months until you are again Eligible for Coverage.

If both spouses are eligible Employees of the Enrolling Group, each may enroll as a Subscriber or be covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Section 2.2 Effective Date of Coverage. Coverage for you and any of your Dependents is effective on the date specified in the Schedule of Covered Dental Services. In no event is there Coverage for Dental Services rendered or delivered before the effective date of Coverage.

Section 2.3 Coverage for a Newly Eligible Person. Coverage for you and any of your Dependents shall take effect on the date specified in the Schedule of Covered Dental Services. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within 31 days of the date you first become eligible.

Section 2.4 Coverage for a Newly Eligible Dependent. Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage shall take effect on the date of the event or on the date adoption proceedings begin. Coverage is effective only if the Company receives any required Premium and is notified of the event within 31 days.

Section 2.5 Special Enrollment Period. An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period or Open Enrollment Period may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met: (a) The Eligible Person and/or Dependent had existing health coverage under another plan at the time of the Initial Eligibility Period or Open Enrollment Period and (b) Coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted. A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay premiums on a timely basis. Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within 31 days of the date coverage under the prior plan terminated. In order for Coverage to continue beyond the 31 days following the event, the Company must receive any required Premium and be notified of the event within those initial 31 days.

A special enrollment period is also available for an Eligible Person and for any Dependent whose status as a Dependent is affected by a marriage, birth, placement for adoption or adoption or adoption proceedings that have begun, as required by federal law. In such cases you must submit the required Premium and a properly completed enrollment form within 31 days of the marriage, birth, placement for adoption or adoption, or the date adoption proceedings begin.

SECTION 3 - TERMINATION OF COVERAGE

Section 3.1 Conditions for Termination of a Covered Person's Coverage Under the Policy. The Company may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Policy. When your Coverage terminates, you may have continuation as described in the Section entitled Continuation of Coverage or as provided under other applicable federal and/or state law.

Your Coverage, including coverage for Dental Services rendered after the date of termination for dental conditions arising prior to the date of termination, shall automatically terminate on the earliest of the dates specified below.

A. The date the entire Policy is terminated, as specified in the Policy. The Enrolling Group is responsible for notifying you of the termination of the Policy.

B. The last day of the calendar month in which you cease to be eligible as a Subscriber or Enrolled Dependent.

C. The date the Company receives written notice from either the Subscriber or the Enrolling Group instructing the Company to terminate Coverage of the Subscriber or any Covered Person or the date requested in such notice, if later.

D. The date the Subscriber is retired or pensioned under the Enrolling Group's Plan, unless a specific Coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

When any of the following apply, the Company will provide written notice of termination to the Subscriber.

E. The date specified by the Company that all Coverage will terminate due to fraud or intentional misrepresentation of a material fact or because the Subscriber knowingly and intentionally provided the Company with false material information, including, but not limited to, false, material information relating to residence information relating to another person's eligibility for Coverage or status as a Dependent. The Company has the right to rescind Coverage back to the effective date.

F. The date specified by the Company that all Coverage will terminate because the Subscriber permitted the use of his or her ID card by any unauthorized person or used another person's card.

G. The date specified by the Company that Coverage will terminate due to material violation of the terms of the Policy.

Section 3.2 Extended Coverage for Handicapped Children. Coverage of an unmarried Dependent child who is incapable of self-sustaining employment because of a handicapped condition will be continued beyond the limiting age provided that:

A. the Enrolled Dependent becomes so incapacitated prior to attainment of the limiting age;

B. the Dependent is chiefly dependent upon the Subscriber for support and maintenance regardless of whether or not they were an Enrolled Dependent prior to becoming incapacitated; and

C. with respect to dependents who become incapacitated after reaching the limiting age, proof of such incapacity and dependence is furnished to the Company within 31 days of the date the Subscriber receives a request for such proof from the Company; and with respect to Enrolled Dependents who are incapacitated while Covered, proof of such incapacity and dependence is furnished to the Company within 31 days of the date the child attains the limiting age; and

D. payment of any required contribution for the Enrolled Dependent is continued.

Coverage will be continued so long as the Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Policy. Before granting this extension, the Company may reasonably require that the Dependent be examined, at the Company's expense, by a Physician designated

by the Company. The Company may require at reasonable intervals thereafter satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at the Company's expense. Such proof will not be required more often than once a year but will not take place before 2 years following the date the dependent reaches the limiting age.

Section 3.3 Extended Coverage. A 30 day temporary extension of Coverage, only for the services shown below given in connection with a Procedure in Progress, will be granted to a Covered Person on the date the person's Coverage is terminated if termination is not voluntary. Benefits will be extended until the earlier of (a) the end of the 30 day period or (b) the date the Covered Person becomes covered under a succeeding policy or contract providing coverage or services for similar dental procedures.

Benefits will be Covered for: (a) a Procedure in Progress or dental procedure that was recommended in writing and began, in connection with a specific dental disease of a Covered Person while the Policy was in effect, by the attending Dentist; (b) an appliance, or modification to an appliance, for which the impression was taken prior to the termination of Coverage; or (c) a crown, bridge or gold restoration, for which the tooth was prepared prior to the termination of Coverage.

Section 3.4 Payment and Reimbursement Upon Termination. Termination of Coverage shall not affect any request for reimbursement of Eligible Expenses for Dental Services rendered prior to the effective date of termination. Your request for reimbursement must be furnished as required in the Section entitled Reimbursement.

SECTION 4 - REIMBURSEMENT

Section 4.1 Reimbursement of Eligible Expenses. The Company shall reimburse you for Eligible Expenses subject to the terms; conditions, exclusions and limitations of the Policy and as described below.

Section 4.2 Filing Claims for Reimbursement of Eligible Expenses. You are responsible for sending a request for reimbursement to the Company's office, on a form provided by or satisfactory to the Company. Requests for reimbursement should be submitted within 90 days after date of service. Unless you are legally incapacitated, failure to provide this information to the Company within 1 year of the date of service shall cancel or reduce Coverage for the Dental Service.

Subject to written authorization from a Subscriber, all or a portion of any Eligible Expenses due may be paid directly to the provider of the Dental Services instead of being paid to the Subscriber.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

A. Your name and address

B. Patient's name and age

C. Number stated on your ID card

D. The name and address of the provider of the service(s)

E. A diagnosis from the Dentist including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim

F. Radiographs, lab or Hospital reports

G. Casts, molds or study models

H. Itemized bill which includes the CPT or ADA codes or description of each charge

I. The date the dental disease began.

J. A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call the Company at the telephone number stated on your ID Card and a claim form will be sent to you. If you do not receive the claim form within 15 days of your request, send in the proof of loss with the information stated above.

Proof of Loss. Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service.

Payment of Claims. Benefits are payable within 60 days after the Company receives acceptable proof of loss. Benefits will be paid to you unless:

A. the provider notifies the Company that your signature is on file assigning benefits directly to that provider; or

B. you make a written request at the time the claim is submitted.

Section 4.3 Limitation of Action for Reimbursement. You do not have the right to bring any legal proceeding or action against the Company to recover reimbursement until 60 days after you have properly submitted a request for reimbursement, as described above. If you do not bring such legal proceeding or action against the Company within 3 years of the expiration date, you forfeit your rights to bring any action against the Company.

SECTION 5 - COMPLAINT PROCEDURES

Section 5.1 Complaint Resolution. If you have a concern or question regarding the provision of Dental Services or benefits under the Policy, you should contact the Company's Customer Service Department at the telephone number or address shown on your ID card.

The Company's authorized representative will contact you and attempt to address the concern through informal discussions. If the issue is not resolved through informal discussions, you may present a written complaint to the Company's authorized representative, who shall notify you of the resolution of the complaint within 30 days following its receipt.

Section 5.2 Complaint Hearing. If you request a hearing, a committee shall be appointed by the Company to resolve or recommend the resolution of the complaint. The Company may consult with, or seek the participation of, medical and/or dental experts as part of the complaint resolution process.

The committee shall advise you of the date and place of a hearing. The hearing shall be held within 60 days following the receipt of the request by the Company, at which time testimony, explanation or other information will be received from those persons deemed by the committee to be necessary for a fair review of the complaint.

The committee shall advise you in writing of its findings within 14 days of the conclusion of the hearing, and of your right to take the grievance to the Office of the Commissioner of Insurance.

Section 5.3 Exceptions for Emergency Situations. The following apply if you have a dispute about a pending Dental Service, which, in the opinion of your Dentist, requires special consideration as an emergency situation. (NOTE: Prescheduled dental treatments or procedures are not considered emergency situations.)

A. The above complaint procedures do not apply; and

B. Your complaint does not need to be submitted in writing; and

C. The Company will notify you of its decision regarding Coverage by the end of the next business day following the date your complaint is registered, if any decision has been made. If the Company requires additional information from your Dentist in order to make a decision, the Company will notify you of its decision by the end of the next business day following receipt of required dental information.

If you are dissatisfied with the Company's decision, you may contact the Office of the Commissioner of Insurance.

SECTION 6 - GENERAL PROVISIONS

Section 6.1 Entire Policy. The Policy issued to the Enrolling Group, including the Certificate of Coverage as Attachment A, the Enrolling Group's application, Amendments and Riders, constitute the entire Policy. All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties.

Section 6.2 Limitation of Action.. If you do not bring such legal proceeding or action against the Company within 3 years of the date the Company notified you of its final decision; you forfeit your rights to bring any action against the Company.

The only exception to this limitation of action is that reimbursement of Eligible Expenses, as set forth in the Section of this Certificate entitled Reimbursement, is subject to the limitation of action provision of that section.

Section 6.3 Time Limit on Certain Defenses. No statement, except a fraudulent statement, made by the Enrolling Group shall be used to void the Policy after it has been in force for a period of 2 years.

Section 6.4 Amendments and Alterations. Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by the Company. No change will be made to the Policy unless it is made by an Amendment or by a Rider that is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

Section 6.5 Relationship Between Parties. The relationships between the Company and Contracting Providers and relationships between the Company and Enrolling Groups, are **solely** contractual relationships between independent contractors. Contracting Providers and Enrolling Groups are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of Contracting Providers or Enrolling Groups.

The relationship between a Contracting Provider and any Covered Person is that of provider and patient. The Contracting Provider is solely responsible for the services provided to any Covered Person.

The relationship between the Enrolling Group and Covered Persons is that of employer and employee, Dependent or other Coverage classification as defined in the Policy. The Enrolling Group is solely responsible for enrollment and Coverage classification changes, including termination of a Covered Person's Coverage through the Company, for the timely payment of the Policy Charge to the Company, and for notifying Covered Persons of the termination of the Policy.

Section 6.6 Records. You must furnish the Company with all information and proofs that it may reasonably require regarding any matters pertaining to the Policy.

By accepting Coverage under the Policy, you authorize and direct any person or institution that has provided services to you, to furnish the Company any and all information and records or copies of records relating to the services provided to you. The Company has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

The Company agrees that such information and records will be considered confidential. The Company has the right to release any and all records concerning dental care services which are necessary to implement and administer the terms of the Policy or for appropriate review or quality assessment.

The Company is or its Contracting Providers are permitted to charge you reasonable fees to cover costs for completing requested dental records or forms that you have requested.

In some cases, the Company will designate other persons or entities to request records or information from or related to you and to release those records as necessary. The Company's designees have the same rights to this information, as does the Company.

During and after the term of the Policy, the Company and its related entities may use and transfer the information gathered under the Policy for research and analytic purposes.

Section 6.7 ERISA. When the Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., the Company is not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Section 6.8 Examination of Covered Persons. In the event of a question or dispute concerning Coverage for Dental Services, the Company may reasonably require that a Contracting Provider acceptable to the Company examine you at the Company's expense.

Section 6.9 Clerical Error. If a clerical error or other mistake occurs, that error shall not deprive you of Coverage under the Policy. A clerical error also does not create a right to benefits.

Section 6.10 Notice. When the Company provides written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons.

Section 6.11 Workers' Compensation Not Affected. The Coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Section 6.12 Conformity with Statutes. Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

SECTION 7 - COORDINATION OF BENEFITS

Section 7.1 Coordination of Benefits Applicability. This coordination of benefits (COB) provision applies when a person has health and dental coverage under more than one Coverage Plan. "Coverage Plan" is defined below.

The order of benefit determination rules below determine which Coverage Plan will pay as the primary Coverage Plan. The primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A secondary Coverage Plan pays after the primary Coverage Plan and may reduce the benefits it pays so that payments from all group Coverage Plans do not exceed 100% of the total allowable expense.

Section 7.2 Definitions. For purposes of this Section, Coordination of Benefits, terms are defined as follows:

A. A "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.

   1. "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.

   2. "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

   Each contract for coverage under (1) or (2) is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

B. The order of benefit determination rules determine whether this Coverage Plan is a "primary Coverage Plan" or "secondary Coverage Plan" when compared to another Coverage Plan covering the person.

   When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan’s benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the primary Coverage Plan’s benefits.

C. "Allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

   1. If a person is covered by 2 or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

   2. If a person is covered by 2 or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

   3. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the

basis of negotiated fees, the primary Coverage Plan's payment arrangements shall be the allowable expense for all Coverage Plans.

4. The amount a benefit is reduced by the primary Coverage Plan because a covered person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and provider arrangements.

D. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

E. "Closed panel Coverage Plan" is a Coverage Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other provider, except in cases of emergency or referral by a panel member.

F. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Section 7.3 Order of Benefit Determination Rules. When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

A. The primary Coverage Plan pays or provides its benefits as if the secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Coverage Plan is:

a. The primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

1) The parents are married;

2) The parents are not separated (whether or not they ever have been married); or

3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or Coverage Plan years commencing after the Coverage Plan is given notice of the court decree.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

1) The Coverage Plan of the custodial parent;

2) The Coverage Plan of the spouse of the custodial parent;

3) The Coverage Plan of the noncustodial parent; and then

4) The Coverage Plan of the spouse of the noncustodial parent.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D(1).

4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.

5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

6. If the preceding rules do not determine the primary Coverage Plan, the allowable expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

Section 7.4 Effect on the Benefits of This Coverage Plan.

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this Coverage Plan would have paid had it been the primary Coverage Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this Coverage Plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Coverage Plan will:

1. Determine its obligation to pay or provide benefits under its contract;

2. Determine whether a benefit reserve has been recorded for the covered person; and

3. Determine whether there are any unpaid allowable expenses during that claims determination period.

If there is a benefit reserve, the secondary Coverage Plan will use the covered person's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

B. If a covered person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the primary Coverage Plan.

- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Section 7.5 Right to Receive and Release Needed Information. Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give the Company any facts it needs to apply those rules and determine benefit payable. If you do not provide the Company the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Section 7.6 Payments Made. A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, the Company may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Coverage Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Section 7.7 Right of Recovery. If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it had paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 8 - SUBROGATION AND REFUND OF EXPENSES

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Company shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits provided by the Company to you from: (i) third parties, including any person alleged to have caused you to suffer injuries or damages; (ii) your employer; or (iii) any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties"). You agree to assign to the Company all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits provided by the Company.

You shall cooperate with the Company in protecting the Company's legal rights to subrogation and reimbursement, and acknowledge that the Company's rights shall be considered as the first priority claim against Third Parties, to be paid before any other claims by you are paid. You shall do nothing to prejudice the Company's rights under this provision, either before or after the need for services or benefits under the Policy. The Company may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name. For the reasonable value of services provided under the Policy, the Company may collect, at its option, amounts from the proceeds of any settlement (whether before or after any determination of liability) or judgment that may be recovered by you or your legal representative, regardless of whether or not you have been fully compensated. You shall hold in trust any proceeds of settlement or judgment for the benefit of the Company under these subrogation provisions. You shall not accept any settlement that does not fully compensate or reimburse the Company without the written approval of the Company. You agree to execute and deliver such documents (including a written confirmation of assignment, and consents to release dental records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as may be reasonably requested by the Company.

Refund of Overpayments. If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person, or

B. All or some of the payment made by the Company exceeded the benefits under the Policy.

The refund equals the amount the Company paid in excess of the amount it should have paid under the Policy.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Reimbursement of Benefits Paid. If the Company pays benefits for expenses incurred on account of a Covered Person, the Subscriber or any other person or organization that was paid must make a refund to the Company if all or some of the expenses were recovered from or paid by a source other than the Policy as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The reduction will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

SECTION 9 - CONTINUATION OF COVERAGE

Section 9.1 Continuation Coverage. A Covered Person whose Coverage would otherwise end under the Policy may be entitled to elect continuation Coverage in accordance with federal law (under COBRA) and as outlined below or in accordance with state law and as outlined in the subsections also shown below.

Continuation Coverage under COBRA shall be available only to Enrolling Groups which are subject to the provisions of COBRA. Covered Persons should contact the Enrolling Group's plan administrator to determine if he or she is entitled to continue Coverage under COBRA.

Continuation Coverage for Covered Persons who selected continuation coverage under a prior plan which was replaced by Coverage under the Policy shall terminate as scheduled under the prior plan or in accordance with the terminating events set forth in Section 9.4 below, whichever is earlier.

In no event shall the Company be obligated to provide continuation Coverage to a Covered Person if the Enrolling Group or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the Covered Person in a timely manner of the right to elect continuation Coverage and notifying the Company in a timely manner of the Covered Person's election of continuation Coverage.

The Company is not the Enrolling Group's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

A Covered Person whose Coverage would otherwise end under the Policy may be entitled to elect continuation Coverage in accordance with federal law, as outlined in Sections 9.2 through 9.4 below.

Section 9.2 Continuation Coverage Under Federal Law. In order to be eligible for continuation coverage under federal law, the Covered Person must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a Qualifying Event:

A. A Subscriber.

B. A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed in adoption with a Subscriber during a period of continuation of coverage, or

C. A Subscriber's former spouse.

Section 9.3 Qualifying Events for Continuation Coverage Under Federal Law. If a Qualified Beneficiary's Coverage will ordinarily terminate due to one of the following Qualifying Events, he or she is entitled to continue Coverage. The Qualified Beneficiary is entitled to elect to continue the same Coverage that he or she had at the time of the Qualifying Event.

A. Termination of the Subscriber from employment with the Enrolling Group (for any reason other than gross misconduct) or reduction of hours, or

B. Death of the Subscriber; or

C. Divorce or legal separation of the Subscriber; or

D. Loss of eligibility by an Enrolled Dependent who is a child; or

E. Entitlement of the Subscriber to Medicare benefits; or

F. The Enrolling Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Section 9.4 Notification Requirements and Election Period for Continuation Coverage Under Federal Law. The Subscriber or Qualified Beneficiary must notify the Enrolling Group's designated plan

administrator within 60 days of his or her divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent If the Subscriber or Qualified Beneficiary fails to notify the designated plan administrator of these events within the 60 day period the Enrolling Group and its plan administrator are not obligated to provide continuation Coverage to the affected Qualified Beneficiary. A Subscriber who is continuing Coverage under Federal Law must notify the Enrolling Group's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the Qualifying Event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Enrolling Group's designated plan administrator.

A Qualified Beneficiary whose Coverage was terminated due to a qualifying event must pay the initial Premium due to the Enrolling Group's designated plan administrator on or before the 45th day after electing continuation.

Section 9.5 Terminating Events for Continuation Coverage Under Federal Law. Continuation under the Policy will end on the earliest of the following dates:

A. Eighteen months from the date of a Qualifying Event for a Qualified Beneficiary whose Coverage would have otherwise ended due to termination of employment (for reasons other than gross misconduct) or a reduction in hours. A Qualified Beneficiary who is determined to be disabled at the time during the first 60 days of continuation Coverage may extend continuation Coverage to a maximum of 29 months from the date of the Qualifying Event described in Section 9.3. If the Qualified Beneficiary entitled to the additional 11 months of Coverage has non-disabled family members who are also entitled to continuation Coverage, those non-disabled family members are also entitled to the additional 11 months of continuation Coverage.

   A Qualified Beneficiary who is determined to have been disabled within the first 60 days of continuation Coverage for Qualifying Event (A)must provide notice of such disability within 60 days after the determination of the disability, and in no event later than the end of the first 18 months, in order to extend Coverage beyond 18 months. If such notice is provided, the Qualified Beneficiary's Coverage may be extended up to a maximum of 29 months from the date of the Qualifying Event described in Section 9.3. A or until the first month that begins more than 30 days after the date of any final determination that the Qualified Beneficiary is no longer disabled. Each Qualified Beneficiary must provide notice of any final determination that the Qualified Beneficiary is no longer disabled within 30 days of such determination.

B. Thirty-six months from the date of the Qualifying Event for an Enrolled Dependent whose Coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child, in accordance with qualifying events (B), (C), or (D) described in Section 9.3.

C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare prior to a Qualifying Event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the Qualifying Event, or if later, 36 months from the date of the Subscriber's Medicare entitlement.

D. The date Coverage terminates under the Policy for failure to make timely payment of the Premium.

E. The date, after electing continuation Coverage, that coverage is obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition of the Qualified Beneficiary, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the preexisting condition limitation or exclusion.

F. The date, after electing continuation Coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event the Qualified Beneficiary's Coverage was terminated because the Enrolling Group filed for bankruptcy, in accordance with qualifying event (F) described in Section 9.3.

G. The date the entire Policy ends.

H. The date Coverage would otherwise terminate under the Policy.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second Qualifying Event occurs during that time, the continuation Coverage of a Qualified Beneficiary who is an Enrolled Dependent may be extended up to a maximum of 36 months from the Qualifying Event described in Section 9.3 A. If a Qualified Beneficiary is entitled to continuation because the Enrolling Group filed for bankruptcy, in accordance with Qualifying Event (F) described in Section 9.3 and the retired Subscriber dies during the continuation period, the Enrolled Dependents shall be entitled to continue Coverage for 36 months from the date of death. Terminating events (B) through (G) described in this Section 9.5 shall apply during the extended continuation period.

Continuation Coverage for Qualified Beneficiaries whose continuation Coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Enrolling Group's designated plan administrator for information regarding the continuation period.

SECTION 10 - PROCEDURES FOR OBTAINING BENEFITS

Section 10.1 Dental Services. You are eligible for Coverage for Dental Services listed in the Covered Services Section of this Certificate if such Dental Services are Necessary and are provided by or under the direction of a Dentist or other provider. All Coverage is subject to the terms, conditions, exclusions and limitations of the Policy.

Contracted Benefits

Dental Services must be provided by a Contracting Dentist in order to be considered Contracted Benefits.

Enrolling for Coverage under the Policy does not guarantee Dental Services by a particular Contracting Provider on the list of providers. The list of Contracting Providers is subject to change. When a provider on the list no longer has a contract with the Company, you must choose among remaining Contracting Providers. You are responsible for verifying the participation status of the Dentist or other provider prior to receiving such Dental Services. You must show your ID card every time you request Dental Services.

If you fail to verify participation status or to show your ID card, and the failure results in non-compliance with required Company procedures, Coverage of Contracted Benefits may be denied.

If you do not have your card at the time you are requesting Dental Services, you or the Provider should call 1-800-822-5353 to obtain eligibility verification. For dental offices with Internet access, the Provider can also access www.dbp.com. This website provides current information on eligibility.

Coverage for Dental Services is subject to payment of the Premium required for Coverage under the Policy, satisfaction of the Annual Deductible, appropriate Waiting Period, and payment of the percentage of Eligible Expenses shown in the Schedule of Covered Dental Services.

Non-Contracted Benefits

Non-Contracted Benefits apply when you obtain Dental Services from Non-Contracting Providers. Non-Contracted Benefits are available for certain Dental Services described in the Section entitled Covered Dental Services.

Before you are eligible for Coverage of Dental Services obtained from Non-Contracting Providers, you must meet the requirements for payment of the Annual Deductible and appropriate Waiting Period specified in the Schedule of Covered Dental Services. Non-Contracting Providers may request that you pay all charges when services are rendered. You must file a claim with the Company for reimbursement of Eligible Expenses.

The Company reimburses a Non-Contracting Provider for a covered Dental Service up to an amount equal to the usual and customary fee for the same covered Dental Service received from a similarly situated Contracting Provider.

Contracting Providers

The Company has arranged with certain dental care providers to participate in a group of Contracting Providers. These Contracting Providers have agreed to discount their charges for Covered services and supplies.

If Contracting Providers are used, the amount of Covered expenses for which a Covered Person is responsible will generally be less than the amount owed if Non-Contracting Providers had been used. The Copayment level (the percentage of covered expenses for which a Covered Person is responsible) remains the same whether or not Contracting Providers are used. However, because the total charges for covered expenses may be less when Contracting Providers are used, the portion that the covered person owes will generally be less.

Covered Persons are issued an identification card (ID card) showing they are eligible for Contracted Benefit discounts. A Covered Person must show this ID card every time dental care services are given. This is how the Provider knows that the patient is Covered under a Contracted Benefits plan. Otherwise, the person could be billed for the Provider's normal charge.

A Directory of Contracting Providers will be made available. A Covered Person can also call Customer Service to determine which Providers participate in the group of Contracting Providers. The telephone number for Customer Service is on the ID card.

Contracting Providers are responsible for submitting a request for payment directly to the Company, however, a Covered Person is responsible for any Copayment at the time of service. If a Contracting Provider bills a Covered Person, Customer Service should be called. A Covered Person does not need to submit claims for Network Provider services or supplies.

Section 10.2 Pre-Determination of Benefits. If the charge for a Dental Service is expected to exceed $200 or if a dental exam reveals the need for fixed bridgework, you should notify the Company of such treatment before treatment begins. You must send the notice to the Company, via claim form, within 20 days of the exam. If requested the Dentist must provide the Company with existing dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will decide if the proposed treatment is Covered under the Policy and estimate the amount of payment. The estimate of benefits payable will be sent to the Dentist and will be subject to all terms, conditions and provisions of the Policy. If a treatment plan is not submitted, the Covered Person will be responsible for payment of any dental treatment not approved by the Company. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-determination of benefits is not an agreement to pay for expenses. This procedure lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment.

SECTION 11 - COVERED DENTAL SERVICES

IMPORTANT NOTICE	AVISO IMPORTANTE
To obtain information or make a complaint, call the Company's toll-free number shown on your ID card.	Para obtener informacion o para someter una queja, usted puede llamar gratis al numero de telefono de la Compania imprimido en su tarjeta de identificacion.
You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at **1-800-252-3439**	Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al: **1-800-252-3439**
You may write the Texas Department of Insurance P.O. Box 149104 Austin, TX 78714-9104 FAX # (512) 475-1771	Puede escribir al Departamento de Seguros de Texas P.O. Box 149104 Austin, TX 78714-9104 FAX # (512) 475-1771
PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.	**DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la Compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).
ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.	**UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Dental Services described in this section are Covered when such services are:

A. Necessary (refer to the Section entitled Definitions);

B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;

C. The least costly, clinically accepted treatment; and

D. Not excluded as described in the Section entitled General Exclusions.

This Schedule of Covered Dental Services (1) describes the Covered Dental Services and any applicable limitation to each service, (2) outlines the Copayments that you are required to pay for each Covered Dental Service and (3) describes the Annual Deductible and any Annual Maximum Benefits that may apply.

Contracted Benefits are subject to the satisfaction of the applicable Waiting Periods, the Annual Deductible and the payment of any Copayments listed below. Covered Dental Services must be provided by or directed by a Contracting Dentist.

When Contracted Benefits Copayments are charged as a percent of Eligible Expenses, the amount you pay for Dental Services from Contracting Providers is determined as a percentage of the negotiated contract fee between the Company and the provider rather than as a percentage of the provider's billed charge. The Company's negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Contracting Provider cannot charge a Covered Person or the Company for any service or supply that is not Necessary as determined by the Company. If a Covered Person agrees to receive a service or supply that is not Necessary the Contracting Provider may charge the Covered Person. However, these charges will not be considered Covered Dental Services and will not be payable by the Company.

Non-Contracted Benefits are subject to the satisfaction of the appropriate Waiting Period, the Annual Deductible and payment of Copayments listed below.

For Contracted and Non-Contracted Benefits, **Annual Deductible** is $50 per Covered Person per calendar year, not to exceed $150 for all Covered Persons in a family. **Annual Deductible** applies to Non-Preventive Dental Services.

Annual Maximum Benefit is $1,500 per Covered Person for Contracted Benefits and $1,500 per Covered Person for Non-Contracted Benefits. The sum of all Contracted and Non-Contracted Benefits will not exceed an Annual Maximum Benefit of $1,500 per Covered Person.

Section 11.1 PREVENTIVE DENTAL SERVICES

BENEFIT DESCRIPTION & LIMITATION	**CONTRACTED BENEFITS COPAYMENT** **The Copayment is shown as a percentage of Eligible Expenses.**	**NON-CONTRACTED BENEFITS COPAYMENT** **The Copayment is shown as a percentage of Eligible Expenses.**
Bacteriologic Cultures.	20%	20%
Bite-Wing Radiographs. Limited to 1 series of films per calendar year.	20%	20%

BENEFIT DESCRIPTION & LIMITATION	CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses.	NON-CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses.
Complete Series or Panorex Radiographs. Limited to 1 time per 36 consecutive months.	20%	20%
Dental Prophylaxis. Limited to 2 times per 12 consecutive months.	20%	20%
Diagnostic Casts. Limited to 1 time per 24 consecutive months.	20%	20%
Extraoral Radiographs. Limited to 2 films per calendar year.	20%	20%
Fluoride Treatments. Limited to Covered Persons under the age of 16 years, and limited to 2 times per 12 consecutive months. Treatment should be done in conjunction with dental prophylaxis.	20%	20%
Individual Periapical Radiographs.	20%	20%
Occlusal Radiographs.	20%	20%
Oral Examinations. Limited to 2 times per 12 consecutive months.	20%	20%
Sealants. Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	20%	20%

Section 11.2 NON-PREVENTIVE DENTAL SERVICES

BENEFIT DESCRIPTION & LIMITATION	**CONTRACTED BENEFITS COPAYMENT** **The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.**	**NON-CONTRACTED BENEFITS COPAYMENT** **The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.**
Minor Restorative Services		
Amalgam Restorations. Multiple restorations on one surface will be treated as a single filling.	20%	20%
Composite Resin Restorations. Multiple restorations on one surface will be treated as a single filling. Covered on anterior teeth only.	20%	20%
Space Maintainers		
Space Maintainers. Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustments within 6 months of installation.	20%	20%
Endodontics		
Apexification.	20%	20%
Apicoectomy and Retrograde filling.	20%	20%
Hemisection.	20%	20%
Root Canal Therapy.	20%	20%

BENEFIT DESCRIPTION & LIMITATION	CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.	NON-CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Root Resection.	20%	20%
Therapeutic Pulpotomy.	20%	20%
Periodontics		
Crown Lengthening.**	20%	20%
Gingivectomy.**	20%	20%
Osseous Graft.**	20%	20%
Osseous Surgery.**	20%	20%
Periodontal Maintenance. Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.	20%	20%
Provisional Splinting.	20%	20%

BENEFIT DESCRIPTION & LIMITATION	CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.	NON-CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Scaling and Root Planing. Limited to 1 time per quadrant per 24 consecutive months.	20%	20%
Soft Tissue Surgery.**	20%	20%
Only one of the above [**] procedures is covered per quadrant or site per 36 consecutive months		
Oral Surgery		
Alveoloplasty.	50%	50%
Biopsy.	50%	50%
Frenectomy.	50%	50%
Incision and Drainage.	50%	50%
Removal of a Benign Cyst.	50%	50%
Removal of Exostosis.	50%	50%

BENEFIT DESCRIPTION & LIMITATION	CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.	NON-CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Root Recovery.	50%	50%
Root Removal.	50%	50%
Simple Extraction.	50%	50%
Surgical Extraction of Erupted Teeth and Roots.	50%	50%
Surgical Extraction of Impacted Teeth.	50%	50%
Adjunctive Services		
Analgesia.	20%	20%
Desensitizing Medicament.	20%	20%
General Anesthesia. Covered only when clinically necessary.	20%	20%

BENEFIT DESCRIPTION & LIMITATION	CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.	NON-CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Intravenous Sedation and Analgesia.	20%	20%
Occlusal Adjustment.	20%	20%
Occlusal Guards. Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.	20%	20%
Palliative Treatment. Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	20%	20%
Major Restorative Services		
Crowns. Limited to 1 time per tooth per 60 consecutive months. Covered only when a filling cannot restore the tooth.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Gold Inlays and Onlays. Limited to 1 time per tooth per 60 consecutive months. Covered only when silver fillings cannot restore the tooth.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Pin Retention. Limited to 2 pins per tooth; not covered in addition to Cast Restoration.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period

BENEFIT DESCRIPTION & LIMITATION	CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.	NON-CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Porcelain Onlays. Limited to 1 time per tooth per 60 consecutive months. Covered only when silver fillings cannot restore the tooth.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Post and Cores. Covered only for teeth that have had root canal therapy.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Re-cement Crowns. Limited to those done more than 12 months after the initial insertion.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Re-cement Inlays. Limited to those done more than 12 months after the initial insertion.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Sedative Fillings. Covered as a separate benefit only if no other service, other than X-Rays and exam, were done on the same tooth during the visit.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Stainless Steel Crowns		
Stainless Steel Crowns.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period

BENEFIT DESCRIPTION & LIMITATION	CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.	NON-CONTRACTED BENEFITS COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Fixed Prosthetics		
Fixed Partial Dentures (Bridges). Limited to 1 time per tooth per 60 consecutive months. Covered only when silver fillings cannot restore the tooth.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Re-cement Bridges. Limited to those done more than 12 months after the initial insertion.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Removable Prosthetics		
Full Dentures. Limited to 1 time per 60 consecutive months. Covered only when silver fillings cannot restore the tooth. No additional allowances for over-dentures or customized dentures.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Removable Partial Dentures. Limited to 1 time per 60 consecutive months. Covered only when silver fillings cannot restore the tooth. No additional allowances for precision or semi precision attachments.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period
Relining Dentures. Limited to relining done more than 6 months after the initial insertions. Limited to 1 time per 12 consecutive months.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period

BENEFIT DESCRIPTION & LIMITATION	CONTRACTED BENEFITS COPAYMENT **The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.**	NON-CONTRACTED BENEFITS COPAYMENT **The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.**
Repairs and adjustments to Full Dentures or~~,~~ Partial Fixed or Removable Dentures. Limited to those done more than 12 months after initial insertion.	50% Subject to a 12 month Waiting Period	50% Subject to a 12 month Waiting Period

Section 11.3 ELIGIBILITY DESCRIPTION

1. Initial Eligibility Period.

The Initial Eligibility Period shall begin on the date determined by the Enrolling Group and the Company and shall end on the date determined by the Enrolling Group and the Company.

The waiting period for small employers can be no more than 90 days.

2. Eligibility.

The following conditions appear on the Application and are in addition to those specified in the Section of the Certificate entitled, Enrollment and Effective Date of Coverage:

A. Waiting or Probationary period for newly Eligible Persons.

B. Excluded classes of persons, if any.

C. Coverage classifications other than employee, if any.

3. Effective Date.

If an Eligible Person enrolls during the Initial Eligibility Period, Coverage is effective on the date in which the Eligible Person joins the Enrolling Group.

SECTION 12 - GENERAL EXCLUSIONS

Section 12.1 Exclusions. Except as may be specifically provided in the Section entitled Covered Services or through a Rider to the Policy, the following are not Covered:

A. Dental Services that are not Necessary.

B. Hospitalization or other facility charges.

C. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

D. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.

E. Any dental procedure not directly associated with dental disease.

F. Any procedure not performed in a dental setting.

G. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

H. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

I. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

J. Services for injuries or conditions covered by Workers' Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

L. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision.

M. Replacement of complete dentures, fixed and removable partial dentures or crowns previously submitted for payment under the Plan within 60 months of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

N. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.

O. Other than the initial diagnosis, all services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery. No Coverage is provided for orthognathic surgery or jaw alignment.

P. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

Q. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.

R. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

S. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

T. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

U. Full mouth radiograph series in excess of once every 36 consecutive months. Panoramic radiographs in excess of once every 36 consecutive months, except when taken for diagnosis of third molars, cysts, or neoplasms.

V. Denture relines for complete or partial conventional dentures for the 6 month period following the insertion of a prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures for the first 6 months. After the 6 month waiting period, relines are covered not more than once every 12 consecutive months.

W. Root planing and scaling (ADA Code 4341) in excess of once every 24 consecutive months per quadrant.

X. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area in excess of once in any consecutive 36-month period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.

Y. Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement in excess of once every 36 consecutive months per quadrant or surgical site.

Z. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.

AA. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been eligible for 12 continuous months.

BB. Billing for incision and drainage (ADA Code 7510) if the involved abscessed tooth is removed on the same date of service.

CC. Full mouth debridement (ADA Code 4355) in excess of once every 36 consecutive months.

DD. Occlusal guards except if prescribed to control of habitual grinding, including those specifically used as safety items or to affect performance primarily in sports-related activities.

EE. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

FF. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

GG. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

HH. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

II. General Anesthesia, except if clinically necessary.

JJ. In the event that a Non-Contracting Provider routinely waives Copayments and/or the Annual Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Annual Deductible are waived is not Covered.

KK. Dental Services provided in a foreign country, unless required as an Emergency.

UNITED HEALTHCARE INSURANCE COMPANY

ORTHODONTIC SERVICES RIDER

The Certificate is modified by the attachment of this Rider to provide Coverage for Orthodontic Services.

ORTHODONTIC SERVICES

Services or supplies furnished by a Dentist to a Covered Person under age 19 in order to diagnose or correct misalignment of the teeth or the bite.

Orthodontic Services are subject to the applicable waiting period, satisfaction of the Annual Deductible and payment of any applicable Copayments as described below.

Not included is the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion.

Pre-Determination of Benefits - If a dental exam reveals the need for orthodontia, you should notify the Company of such treatment before treatment begins. You must send the notice to the Company, via claim form, within 20 days of the exam. If requested the Dentist must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will decide if the proposed treatment is Covered under the Policy and estimate the amount of payment. The estimate of benefits payable will be sent to the Dentist and will be subject to all terms, conditions and provisions of the Policy. If a treatment plan is not submitted, the Covered Person will be responsible for payment of any dental treatment not approved by the Company. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-determination of benefits is not an agreement to pay for expenses. This procedure lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment.

WAITING PERIOD

12 months for Orthodontic Services provided by a Contracted Dentist.

12 months for Orthodontic Services provided by a Non-Contracted Dentist.

CONTRACTED/NON-CONTRACTED COPAYMENT

A Contracted/Non-Contracted Copayment is the charge which you are required to pay for Orthodontic Services payable under the Policy. The Contracted/Non-Contracted Copayment is shown below as a percentage of Eligible Expense after the Annual Deductible is satisfied:

50% for Orthodontic Services rendered by a Non-Contracted Dentist. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.

ORTHODONTIC MAXIMUM

The sum of all benefits payable for Covered Orthodontic Services in a Covered Person under 19's lifetime will not exceed $1,000.

NOTE: The Extended Coverage provision in the Certificate does not apply to Orthodontic Services Covered through this Rider. All other provisions that appear in the Certificate apply to Orthodontic Services.

UNITED HEALTHCARE INSURANCE COMPANY

Allen J. Sorbo, President

Notices

Claims and Appeal Notice

COBRA Notice

Notice of Privacy Practices

Financial Information Privacy Notice

ERISA

Claims and Appeal Notice

This Notice is provided to you as a result of changes in federal law regarding our responsibilities for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-Service Claims

Post-service claims are those claims that are filed for payment of benefits after dental care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving dental care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from us within 15 days of receipt of the claim. If you filed a pre-service claim improperly, we will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, we will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Attention

Urgent claims are those claims that require notification or a benefit determination prior to receiving dental care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If you filed an urgent claim improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, we will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our customer service department before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a customer service representative. If you first informally contact our customer service department and later wish to request a formal appeal in writing, you should again contact customer service and request an appeal. If you request a formal appeal, a customer service representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to the *Urgent Claim Appeals that Require Immediate Action* section below and contact our customer service department immediately.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact us in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of dental service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-service and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of **pre-service claims** as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of **post-service claims** as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see *Urgent Claim Appeals That Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure. We don't determine whether the pending dental service is necessary or appropriate. That decision is between you and your dental provider.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

COBRA Notice

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your enrolling group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the policy on the day before a qualifying event:

- A subscriber.
- A subscriber's enrolled dependent, including with respect to the subscriber's children, a child born to or placed for adoption with the subscriber during a period of continuation coverage under federal law.
- A subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of the subscriber from employment with the enrolling group, for any reason other than gross misconduct.

B. Reduction in the subscriber's hours of employment.

With respect to a subscriber's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

A. Termination of the subscriber from employment with the enrolling group, for any reason other than the subscriber's gross misconduct.

B. Reduction in the subscriber's hours of employment.

C. Death of the subscriber.

D. Divorce or legal separation of the subscriber.

E. Loss of eligibility by an enrolled dependent who is a child.

F. Entitlement of the subscriber to Medicare benefits.

G. The enrolling group filing for bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired subscriber and his or her enrolled dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

Notification Requirements for Qualifying Event

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator within 60 days of the latest of the date of the following events:

- The subscriber's divorce or legal separation, or an enrolled dependent's loss of eligibility as an enrolled dependent.
- The date the Qualified Beneficiary would lose coverage under the policy.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The subscriber or other Qualified Beneficiary must also notify the enrolling group's plan administrator when a second qualifying event occurs, which may extend continuation coverage.

If the subscriber or other Qualified Beneficiary fails to notify the enrolling group's plan administrator of these events within the 60 day period, the plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a subscriber is continuing coverage under federal law, the subscriber must notify the enrolling group's plan administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the enrolling group's plan administrator at the address stated in the ERISA Statement. The contents of the notice must be such that the plan administrator is able to determine the covered employee and Qualified Beneficiary or beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the subscriber or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the enrolling group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the plan administrator.

The Qualified Beneficiary's initial premium due to the plan administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If you qualify or may qualify for assistance under the Trade Act of 1974, contact the enrolling group for additional information. You must contact the enrolling group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the policy will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

   - Notice of such disability must be provided within the latest of 60 days after:
     - the determination of the disability; or
     - the date of the qualifying event; or
     - the date the Qualified Beneficiary would lose coverage under the policy; and
     - in no event later than the end of the first eighteen months.
   - The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.
   - If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

   Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an enrolled dependent whose coverage ended because of the death of the subscriber, divorce or legal separation of the subscriber, or loss of eligibility by an enrolled dependent who is a child (i.e. qualifying events C., D., or E.).

C. With respect to Qualified Beneficiaries, and to the extent that the subscriber was entitled to Medicare prior to the qualifying event:

   - Eighteen months from the date of the subscriber's Medicare entitlement; or
   - Thirty-six months from the date of the subscriber's Medicare entitlement, if a second qualifying event (that was due to either the subscriber's termination of employment or the subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the subscriber became entitled to Medicare subsequent to the qualifying event:

   - Thirty-six months from the date of the subscriber's termination from employment or work hours being reduced (first qualifying event) if:

- The subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
- if, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the policy for failure to make timely payment of the premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the enrolling group filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the enrolling group filed for bankruptcy, (i.e. qualifying event G.) and the retired subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the subscriber's death.

H. The date the entire policy ends.

I. The date coverage would otherwise terminate under the policy.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We* are required by law to protect the privacy of your health information. We are also required to send you this notice which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our website, www.myuhc.com.

*For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities: All Savers Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Rooney Life Insurance Company; Spectera, Inc; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- For Payment of premiums due us and to process claims for health care services you receive.
- For Treatment. We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- For Health Care Operations. We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- To Provide Information on Health Related Programs or Products such as alternative medical treatments and programs or about health related products and services.
- To Plan Sponsors. If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- For Appointment Reminders. We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- To Persons Involved With Your Care. We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- For Public Health Activities such as reporting disease outbreaks.
- For Reporting Victims of Abuse, Neglect or Domestic Violence to government authorities, including a social service or protective service agency.
- For Health Oversight Activities such as governmental audits and fraud and abuse investigations.
- For Judicial or Administrative Proceedings such as in response to a court order, search warrant or subpoena.
- For Law Enforcement Purposes such as providing limited information to locate a missing person.
- To Avoid a Serious Threat to Health or Safety by, for example, disclosing information to public health agencies.
- For Specialized Government Functions such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- For Workers Compensation including disclosures required by state workers compensation laws of job-related injuries.
- For Research Purposes such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- To Provide Information Regarding Decedents. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- For Organ Procurement Purposes. We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.

If none of the above reasons applies, **then we must get your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact the phone number listed on your ID card.

Highly Confidential Information

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

What Are Your Rights

The following are your rights with respect to your health information.

- ***You have the right to ask to restrict*** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. ***Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.***
- ***You have the right to ask to receive confidential communications*** of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address).
- ***You have the right to see and obtain a copy*** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary

of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.

- ***You have the right to ask to amend*** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- ***You have the right to receive an accounting*** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- ***You have the right to a paper copy of this notice.*** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.myuhc.com.

Exercising Your Rights

- ***Contacting your Health Plan.*** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- ***Filing a Complaint.*** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

United Healthcare
Customer Service - Privacy Unit
PO Box 740815
Atlanta, GA 30374-0815

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

Financial Information Privacy Notice

Effective: April 14, 2003

We (including our affiliates listed at the bottom of this page)* are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

* For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group, Inc.; ACN Group of California, Inc.; ACN Group IPA of New York, Inc.; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Coordinated Vision Care, Inc.; DBP-KAI, Inc.; Disability Consulting Group, LLC; DCG OnLine, LLC; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; Dental Insurance Company of America; EverCare of New York, IPA, Inc.; Fidelity Benefit Administrators, Inc.; Lifemark Corporation; MAMSI Insurance Agency of the Carolinas, Inc.; MAMSI Insurance Resources, Inc.; Managed Physical Network, Inc.; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources, Inc.; Uniprise, Inc.; United Behavioral Health of New York, IPA, Inc; United HealthCare Services, Inc.; United HealthCare Service LLC.

ERISA

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire

you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Security Benefits Administration, United States Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Security Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Security Benefits Administration.

ERISA Statement

If the Enrolling Group is subject to ERISA, the following information applies to you.

Summary Plan Description

Name of Plan: City of Arlington Texas Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

City of Arlington Texas
201 E. Abram, Suite 790
Mail Stop 63-0790, PO Box 790
Arlington, TX 76004
(817) 459-6853

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Claims Fiduciary:

United HealthCare Insurance Company

Employer Identification Number (EIN): 75-6000450

IRS Plan Number: 501

Effective Date of Plan: January 1, 2007

Type of Plan: Health care coverage plan

Name, business address, and business telephone number of Plan Administrator:

City of Arlington Texas
201 E. Abram, Suite 790
Mail Stop 63-0790, PO Box 790
Arlington, TX 76004
(817) 459-6853

Type of Administration of the Plan:

Benefits are paid pursuant to the terms of a group health policy issued and insured by:

United HealthCare Insurance Company

The Plan is administered on behalf of the Plan Administrator by United HealthCare Insurance Company.

Person designated as agent for service of legal process: Plan Administrator

Source of contributions and funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for premiums under the Plan. Benefits under the Plan are funded by the payment of premium required by the group policy.

Method of calculating the amount of contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will

determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Date of the end of the year for purposes of maintaining Plan's fiscal records: Plan year shall be a twelve month period ending December 31.

Determinations of Qualified Medical Child Support Orders. The plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.